The Hampden Hippocrat

APRIL, 1973

ANNUAL MEETING ISSUE

HAMPDEN DISTRICT MEDICAL SOCIETY

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THE HAMPDEN HIPPOCRAT
·1942·

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A bulletin for
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The Massachusetts
Medical Society

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Editorial . . .

WHOLE = SUM OF PARTS

With our annual meeting shortly upon us and a new year of activity about to begin, we should take stock of what recent events point up and what our guide to the future should be. The national pastime of "physician baiting" and "physician scapegoating" has intensified with the emphasis gradually shifting from organized medicine on all levels to individuals and groups of physicians. There is a seeming conspiracy that thrives in depicting physicians as not being interested in the public good but rather as highly vested and prejudiced "money grubbers". Moreover, these same forces fully realize that "public opinion is the most powerfull determinant and the ultimate force that in the long run will determine the social, economic, and political course in this country" and along with it the destiny of health care. The battle cry seems to be that "health is too important to be left in the hands of physicians." It is openly manifest that the movement to place leadership, standard setting, and goals in matters pertaining to health in the hands of those outside the medical profession is fast gaining momentum. Therein lies the challenge to the followers of the art.

DIVISIVENESS

There is probably no other profession that has as many simultaneous demands being made upon its interests and loyalties than the medical profession. By the same token, these demands tend to be divisive. Within the profession there are such divergent interests as the interplay between the specialist and the generalist; the inner city, the suburban, and the rural practitioners; the practitioner, the educator, the researcher, and the administrator; one hospital affiliation and another; one specialty group and another; the salaried and the fee-for-service practitioner; the group and the solo practitioner; etc. The opposition is fully aware of these divisive forces and is not only taking advantage of same but also devisively gloating thereover.

UNITY

The future of each and every physician depends on his or her own attitude and activity. No one of us can stem the tide alone, but together with persistence we can not only move a mountain, but fashion it for our own good and that of all the people.

Our common bond is our profession and our instruments – our medical society with its progeny the "foundation for medical care" and not a "union". No organization has any verity unless it is reflected in the personal and professional lives

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of its members, and this points up the old axiom that the whole is but a sum of its parts.

To justify the existence of our common bond – our profession and its instruments, it behooves each and every one of us as well as our instruments to be unified, dedicated, and constructively motivated to serve not just ourselves but primarily the common good. Unionization for the purpose of confrontation – inevitably with government – can only lead to the downfall of physicians. Events occurring a few years ago in Quebec bear witness to the certainty of same. Our colleagues there advise discussion and counsel with an eye to evolving mutually satisfying solutions even in the face of mutual compromise. Militant confrontation can only cause physicians to lose the most, for schemes will be effected by representatives of the vox populi with or without assistance from the medical profession and despite obvious disadvantages to the common good.

LEADERSHIP

Abraham Lincoln once said: "Public sentiment is everything; with public sentiment, nothing can fail; without it, nothing can succeed. He who molds opinion is greater than he who enacts laws." Since change is inevitable; then let us direct the change properly through our medical societies and our foundations for medical care. Each one of us must extend ourselves more by keeping abreast of all issues, by communicating our thoughts to our organizations' officers and committees, by participating strongly and unselfishly in our various organizations' activities and by communicating our unified and concerned actions to the public. Each one of us must contribute our share and more in a united way or become puppets manipulated by demagogues promising utopia but expecting us to deliver it or else.

Ayres

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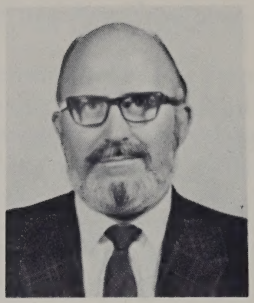

President's Page

ADIEU

It does not seem so, but apparently, the year has come to an end for me as President of your Medical Society. It has been a very eventful, a very busy, and a very monumental year not only for me but also for our Society. I leave to my successor, Dr. Zacarian, many problems as yet totally unsolved. However, as I have stated many times during the year, we still are in a position to salvage some elements of our profession's freedom of thought, freedom of treatment, and freedom of choice of physician.

Many of these freedoms that we have loved through the years are slowly being strangled and taken from us today by the consumerism proponents in our society. Unfortunately in consuming, one destroys from the very nature of the word. I have tried through the year to point out that the proper use of words is important because in choosing our words and saying what we do, we get the exact meaning of the situation before us. As I pointed out in my talk of one year ago, in the *Declaration of Independence* there is the word "foundation", and on this foundation, we hope to be able to maintain our freedom as citizens, as physicians, and as men. Unfortunately, within our own ranks, there are some who do not see this and who are unfortunately blinded as to what the true meaning of the governmental control of medicine would lead to.

I need only to point out to you some instances of such governmental interventions as the Commonwealth of Massachusetts requiring a surcharge of ten dollars from each physician for a BNDD number which the federal government has already placed on us. The question of re-licensing each year for a rather large fee has come up again under the guize of saying one has to be educated. I feel that we physicians have done a fine job through the years of educating ourselves. The patients have forced us to educate ourselves. Patients have demanded more care and have demanded more knowledge from us. To me, the final test of physicians is how patients respond to treatment.

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The only people capable of reviewing the quality of the work we do is not the plumber, not the carpenter, or the engineer, but a fellow physician. On this basis, I am entering my final plea to you to point out that the only ones who can review our work on the P.S.R.O., which is now law, must be fellow physicians and our Foundation must be designated as the approved agency for this area.

According to the law as written and according to what Senator Bennett has said, we present an ideal situation for designated area consisting of the entire section of Western Massachusetts – one portion of a state. In the Commonwealth of Massachusetts, there are at least two other foundations functioning – the Bay State and the Barnstable County Foundations. With these three, the Commonwealth is fulfilling the requirements of a P.S.R.O. under the guidance of the Commonwealth Institute of Medicine.

I want to thank all the members of the various committees who worked so diligently during this past year, particularly, the Executive Committee, which worked faithfully and assiduously in trying to make the Foundation a living concept instead of just an idealistic thought. I wish to thank Mrs. Vivian Purdy, who worked hard for many hours beyond the call of duty. She attended many meetings and came back with information for dissemination so that you would be cognizant of the various, rapid changes which are occurring in our government today in regard to the delivery of medical care.

Robert N. LaMarche M.D.

Robert N. LaMarche, M.D.

THE NEXT MEETING of the ACADEMY OF MEDICINE

will be held on
TUESDAY, MAY 8, 1973
ANNUAL MEETING – ELECTION OF OFFICERS

Speaker: ROBERT E. DREWERY, M.D.
Director, Extended Care Unit
Lock Haven General Hospital
Lock Haven, Pennsylvania

Topic: "REHABILITATION"

Program: Social Hour 6:30 P.M.
Dinner 7:00 P.M.
Business meeting 8:00 P.M.
Robert E. Drewery, M.D. 8:15 P.M.

Reservations:
Please call Mrs. Mildred Lund at 734-5445
before Friday, May 4, 1973

STANDARDIZATION OF FEES AND PRACTICES

During the year of 1972, the currents of change have not only further disturbed our equanimity, but have propelled us a step closer to new horizons which we must now face. One cannot help but feel that time is running out and that the tempo is quickening.

SOCIO-ECONOMICS

New developments of a socio-economic nature are requiring that in addition to concerning ourselves with the quality of medical and surgical care, we must now assume new responsibilities and become involved in today's vital issues that have to do with the following: (a.) improvement of care for those with relatively less care, (b.) financing of health care, (c.) peer review organizations, (d.) utilization functions, and finally, but not least important, (e.) the establishment of a fee system for surgical and medical services that will be clearly understandable and readily acceptable to carriers and governmental agencies. It is no secret that the entire "fee for service" concept is being threatened by political and national planners, whose decision making is not necessarily motivated by sincere concern for the public's welfare, and certainly not by concern for our well being.

It appears to be fairly evident that as we proceed into and age of PSRO's, HMO's, review committees, contractual arrangements with government and industry, and with greater and greater use of capitation and pre-payments systems, we can no longer consider acceptable a completely individualized system with no negotiability or predictiveness of cost, and most important, with no control by our peers or our parent organization.

A recent national periodical (July '72) reported on an interview with Dr. Luther L. Terry, former Public Health Service Surgeon General, who was a key figure in Washington for two decades of American health history – during the era of LBJ, JFK, Medicare and the A.M.A. I doubt that one could find any other person so knowledgeable and so apt to prophesy with accuracy regarding matters of medical economics. From that interview I shall quote two selected statements that I feel are pertinent:

"1. Within the next two years we can expect some major federal legislation directed towards some type of compulsory prepaid medical care.
2. Everything we are doing now is moving toward a standardization of medical fees and practices. This is being pushed on the medical profession by the government."

Much enthusiasm is being displayed in many areas in favor of a unionization of doctors. Whether one agrees or disagrees with such a movement does not alter the fact that unionization in essence implies a standardization of fees and practices.

The foundation concept being developed by our District Society, which most of us feel offers a more professional method of organization, cannot function effectively without standards, not only in regard to quality and utilization procedures, but also in regard to fee discussions.

THE RVS

The formal adoption of the relative value guide by various state medical societies has been a giant step forward in putting fees on a responsible, predictable, fair-minded, and yet reasonably flexible basis. The enormous potential benefits of this step are being largely vitiated by the inability or delay in agreeing on the best use of one small but wholly critical number, the conversion factor.

All who have followed the development of the relative value guide have admired the neatly interlocking function of the two central concepts that make this system run: the unit value and the conversion factor. The unit value, as

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utilized in the Massachusetts Relative Value Study represents that investment of time, thought, knowledge, skill, responsibility, and after care that each procedure demands relative to any other procedure. The conversion factor, when multiplied by the unit value, produces the dollar value of the generally prevailing fee in Massachusetts for that procedure.

(a.) The important point to emphasize in this arrangement is that the effectiveness of the whole MRVS depends upon a fairly uniform use of the conversion factor. Otherwise a "jockeying" for position will develop with a "stepladdering" rise in charges resulting. If a majority of specialty members decide that certain procedures are not adequately compensated, they should request of the Interspecialty Committee (MMS) that the unit value be changed or revised appropriately.

What would be the advantages if our entire membership were to use a relatively uniform conversion factor, with some variation allowed for different regions of the country and with some range being allowed dependent upon modifying factors that will be established by the parent groups.

1. *Simplicity of negotiation.* In any contractual relationship with one of several third parties: Medicare, Medicaid, Blue Shield, the Industrial Accident Board, the private insurance carriers, the Rate Setting Commission, or their successors, only one number – the conversion factor – requires discussion.
2. *Cost predictiveness.* The greatest single fear of any governmental agency, industry, and all third parties is the possible escalation of medical or surgical fees during any contract period. A reasonable conversion factor adopted by our membership and the other medical and surgical specialties will make cost predictiveness realistic, and will tend to forestall the imposition of a truly fixed and less advantageous fee schedule across the board.
3. *Flexibility.* The relative value system allows easy revision of the conversion factor in accord with the cost of living index. With conversion factors varying from physician to physician, this nice adjustment becomes impossible. The "modifying factors" permit flexibility.
4. *Control of over-charging.* Third parties will take an increasingly hard look for over-charging and the bureaucratic controls will multiply. If each physician were to select his own conversion factor based upon his own appraisal of his abilities or needs, over-charging would become increasingly common. Peer review by their fellows would be a time-wasting, bitter and divisive practice. Who would do it?
5. *The public and private image of physicians.* The public tends to think of physicians as rich and well paid. Doubtless many feel that high and rising medical fees are a big factor in the sharply rising costs of medical care. If a majority of physicians could produce a responsible, fair, and self-controlling system of fees, this justly would merit wide public approval.

Regardless of how we may have cherished our ancient traditions, we must recognize that in 1973 they have become just that – traditions. A glance at the various health measures being proposed by our federal law makers reveals that most contain provisions for the establishment of non-negotiable fee schedules. Our choice appears to be quite simple; either we actively lead with positive recommendations which will be supported by the public, or we again adopt holding tactics and await the inevitable.

Mozden

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One Man's Opinion . . .

"ROOM AT THE TOP" REMEMBERED

A bit of a stir was created locally as well as in Boston by an editorial in *The Hampden Hippocrat* of May, 1967.

Briefly, the editorial, entitled "Room at the Top" proposed ways and means of improving the rapport between district societies and the MMS, as well as with one another. The first suggestion was that the MMS" . . . offer its districts more positive and more vigorous leadership. All of the major programs of Hampden during the last decade or two were initiated by local leadership . . . It seems logical to assume, however, that a few ideas and suggestions from Boston might well have stimulated us from time to time to even greater heights of effort and accomplishment."

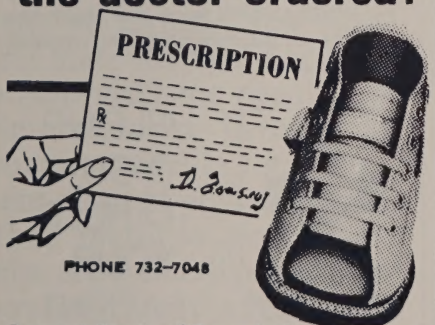
The second suggestion was based on the fact that as a district society we have no way of knowing what other districts are doing. To remedy the situation the editorial proposed ". . . the establishment of a 'clearing house' for all state-wide activities. The *MMS Newsletter,* for instance, might be expanded to serve as a central communication agency publicizing regularly all significant district activities. . ."

The local favorable reaction to the editorial was not too surprising. For some time now complaints have been heard that in many ways Chicago seemed closer to us than Boston. This is another way of saying that over the years we have received more ideas and more guidance from the AMA than the MMS. Moreover, the editorial, as it points out, was prepared not only after due deliberation but also considerable discussion with local leadership and membership.

THE RESPONSE FROM BOSTON

Most gratifying, however, was the response from our state capital. After saying a few kind words about *The Hampden Hippocrat* in general, Carl Bearse, M.D., writes: "The lead editorial in the May, 1967 issue . . . is most constructive. The suggestion that rapport between district societies and the Massachusetts Medical Society be improved is one which I wholly support." Dr. Bearse, it should be noted, is a past

We have just what the doctor ordered!



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President of the MMS and editor of *The Massachusetts Physician. (The Hampden Hippocrat,* June, 1967).

The same issue of *The Hampden Hippocrat* carries a letter from Thomas Gephart, M.D., Secretary of the MMS. "... we accept", he writes, "the challenge to offer more suggestions, and in fact would appreciate the opportunity to meet informally with members of your Executive Committee to discuss frankly and in detail mutual problems – local and state-wide."

As to the second recommendation, Dr. Gephart writes: "Your suggestion of having the *Newsletter* serve as a 'clearing house' for all statewide activities is a good one. Headquarters in the past has not been informed of district activities – in fact, we are not even advised in advance of the dates of district society meetings. I am personally taking on the project of developing better communications between this office and those of 21 district secretaries."

We see then that the recommendations of "Room at the Top" received widespread approval. Hope ran high especially in view of the last paragraph of Dr. Gephart's letter: "You are right in stating the '22 The Fenway will more than welcome the suggestions embodied in the above paragraphs." Some envisioned the MMS inviting its district societies to report regularly on their meetings, programs, projects, and other pertinent plans and activities. These activities, hopefully, would then be publicized in the pages of the *MMS Newsletter.* Others went as far as to visualize our parent organization sending emissaries to the hinterland to advise the grassroot membership on what's going on and especially on what's to be done. The ultimate choice of action, as usual, would remain with each district society.

The main reason for recalling "Room at the Top" at this time is because never before was the need for unity and coordination as great as it is at the present time. Our profession finds itself caught in the maelstrom of a silent, and perhaps not-so-silent, revolution. The seriousness of the situation was well summarized by President LaMarche in his splendid President's Page of February, 1973, issue of *The Hampden Hippocrat.* No one expects all suggestions reaching the MMS office to be implemented but it would seem that anything even remotely promising some degree of improvement in communication, is worthy of consideration.

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THE CONTRACEPTIVE HYSTERECTOMY

The great debate of the 70's reads "Is hysterectomy a justifiable procedure in contraception?" Ten years ago the title of the great debate was "Is a definitive sterilization procedure justified?" Twenty years ago the title was "Is conception control morally or ethically right?" The controversy actually began in 1879 when removal of the uterus was first suggested as a sterilization procedure, and over the ensuing years the arguments for hysterectomy have become more convincing. Despite the fact that elective hysterectomies have long been singled out as examples of unnecessary and potentially risky surgery, they seem to be gaining acceptance among women and physicians seeking foolproof contraception. Across the United States there is a 50-78% rise in hysterectomies – most of the rise being attributed to the marked increase in elective vaginal hysterectomies, despite the fact that this procedure requires more skill than the abdominal hysterectomy.

What reasons do the proponents of the contraceptive vaginal hysterectomy advance? The most obvious advantage is its virtual infallability as a contraceptive measure. Between 1895 and 1968 the world literature reports 12 ectopic pregnancies after hysterectomy as opposed to a tubal ligation failure rate of up to 2%.

The operation has become one of the safest major operations a gynecologist can advise today with an overall mortality rate of 0.13% or much less if one confines the operation to young healthy subjects such as those in the contraceptive hysterectomy group.

The contraceptive hysterectomy is ideal for high risk groups of patients such as those with abnormal "Pap" smears showing dysplasia, patients with pelvic floor relaxation, patients with systemic disease that manifests pelvic symptoms (hypertension, diabetes, etc.), or patients with benign pelvic pathology resulting in pelvic disability. Studies have shown that these patients will ultimately require hysterectomy for these conditions. At Vanderbilt University 8.2% of the patients with tubal ligation developed gynecologic disorders (mostly abnormal bleeding) within one year and 31% within 10 years. The overall incidence of abnormal bleeding in this group was triple the incidence of that in the general population of the same age group.

In the low-income, high-parous group of women where the incidence of cervical cancer on long term follow up was found to be 28.9 per 1,000 women as opposed

to 8.4 per 1,000 in the general female population, the prophylactic contraceptive hysterectomy takes on new meaning. Although this is a very select group, it is even more important when we realize that the return for gynecologic check-up following tubal ligation is infrequent or non-existent in this select group.

Psychologists have concluded that hysterectomy is not nearly as traumatic an experience as generally believed, especially if the patient and her husband are informed as to the side effects or lack of them as well as the permanence and irreversibility of contraception. Patterson from Columbia University reported that although psycho-sexual problems are frequently present in women prior to hysterectomy, the pattern of sexual activity is described by patient and husband was more often improved than otherwise. Indeed, many potential psychiatric problems are actually avoided in these patients by alleviating sexual and reproductive problems as the result of a permanent surgical procedure. Scott from Leeds University found that women who had tubal ligations often later require hysterectomy because functional symptoms and inconveniences of menstruation which they previously tolerated are no longer acceptable in their sterile state.

We physicians are becoming more aware of the fact that not all women regard the monthly appearance of the menses as necessary for the self image of femininity and usefulness. For those women that do, their wishes should be respected; nevertheless, the way of life has changed so much that their group comprises a small and dwindling minority.

The greatest disadvantage of the contraceptive hysterectomy as opposed to tubal ligation is the morbidity and cost. Although the vaginal hysterectomy is indisputably safe, it does have a morbidity rate triple that of tubal ligation (29% vs. 9%). The cost must be measured in terms of time and money. The cost of a hysterectomy is almost triple that of a tubal ligation in terms of dollars and four to five times that in terms of time spent in hospital and recuperation at home. With the introduction of the laparoscope, tubal sterilization has become an out-patient procedure with less than a day's incapacitation.

Undoubtedly it will be the patient who will make the decision. "No monthly curse – no napkin – no tampons – no accidents – no embarrassments – no staying at home – no pouring over a calendar to see if a trip is feasible". With the advent of the contraceptive hysterectomy it would seem that the Women's Liberation Movement can finally approach the timeless freedom of the male.

Zadworny

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In Memoriam

LEO J. BERNIER, M.D.

1906 - 1973

Dr. Leo J. Bernier of 74 Fairfield Ave., Holyoke, died at the Mass. General Hospital, Boston, on March 9, 1973.

Born in Warren, R. I., on September 30, 1906, Dr. Bernier attended Providence College in Providence, R. I., and received his doctorate of medicine from Syracuse University School of Medicine in 1930. He interned at the Faxton Hospital in Utica, N. Y., and the Jackson Memorial Hospital, in Miami, Fla. In 1932, he came to Holyoke where he entered into the private practice of medicine with special concentration in the field of general surgery.

Dr. Bernier served on the medical staffs of the Holyoke Hospital and the Providence Hospital for many years. He was a member of the Military Surgeons of the U.S., AMA, MMS, and HDMS. During Wrold War II, he served in the U.S. Navy Medical Corp.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

MARK YOUR CALENDAR NOW!

HDMS Annual Meeting, April 24
HDMS Executive Committee Meetings, May 15 and June 12
MMS Council Meeting, Boston, May 23
MMS Annual Meeting, Boston, May 29-31
American Psychiatric Association, Honolulu, May 7-11
American Gastroenterological Association, New York, May 20-26
American Industrial Hygiene Association, Boston, May 20-25
American College of Obstetricians and Gynecologists, Bal Harbour, Fla., May 21-24
American Electroencephalographic Society, Boston, June 14-16
American Diabetes Association, Chicago, June 23-24
AMA Annual Meeting, New York, June 23-28

Ernest A. Byron, Jr.

* * * * * *

SPRINGFIELD

HDMS COMMITTEES ANNUAL REPORTS 1972-1973

THE SECRETARY

Twelve months have rapidly passed, since the Secretary's pen was passed from Setrag Zacarian's hand to mine. In this year, my faith in the mission of organized medicine grew and I, as should you, was reassured that the Hampden District Medical Society is a viable aggressive society which is concerned with the problems of physicians and their patients.

Twelve months during which time the Medical Foundation has been advanced by Drs. LaMarche and Bandeian. In this year, the Hampden District Medical Society was well represented in the MMS Council and the extended invitation to host a Council meeting was duly recorded.

Twelve months in which nine members deceased, six transferred out, eighteen new members joined and three transferred into the Society. This makes a total membership of five hundred twenty-seven. We are the fifth largest district society in the Commonwealth. In this year major relocations of physicians into new offices occurred and the new Mercy Hospital was started.

Twelve months in which a new emphasis called "consumerism" emerged as a very potent factor influencing the delivery of health care and which must be channeled properly so that the hand that feeds us does not injure itself for lack of knowledge. In this year another potent force emerged under the aegis of the Department of Public Health. A head-on collision of the Medical Society and the Department may ensue. The rights of a duly licensed physician should not be abrogated by revision of rules and regulations; only the General Court has this power.

Twelve months in which at the national level, organized medicine, viz AMA looked at itself and has begun extensive self revision so that it will be a vital agent for the last quarter of this century. The C.I.M. will act as a similar catalyst for the Massachusetts Medical Society. In this year physicians in general became aware of the increasing need for continuing their medical education and the recertification of specialists became a point of discussion.

Twelve months in which the Grievance Committee met after each Executive Committee meeting and a total of 38 grievances, complaints and problems were investigated. Eleven were forwarded to

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the Peer Review Committee. The bulk of the grievances resulted because patients felt that they had been overcharged for the physicians services and were settled when a full explanation was forthcoming. A few complaints indicated that there are among us several who should be dropped from our ranks and who should have their licenses revoked. This will be one of the tasks for our next year.

Overall the health of the district society is good and the membership is keeping up with our changing medical world.

Walton E. Stevens, M.D.

BOARD OF EDITORS
"THE HAMPDEN HIPPOCRAT"

The submission of this report marks the completion of thirty-one years of publication by *The Hampden Hippocrat* on behalf of the HDMS. During 1972-1973, the bulletin continued to appear monthly except for July and August with all issues consisting of 32 pages, primarily, because of financial limitation. During the year, *The Hampden Hippocrat* made every effort to present various views on such local, state, and national issues as Health Care Foundations, physicians' fees, legislation, malpractice insurance, P.S.R.O.'s national health insurance, Blue Shield matters, peer review, and physicians' unions. The traditional "special theme" issues included medicine and religion, the Woman's Auxiliary, and legislation. Much space and copy were devoted to the conception and promotion of the Health Care Foundation of Western Mass., Inc.

During the year, three Associate Editors resigned, namely, Dr. Frank G. Mills, Dr. William E. Nessell, and Dr. Roland F. Stebbins. One vacancy was filled with the appointment of Dr. James D. Allan.

Financially, *The Hampden Hippocrat* did not have to tap its financial reserves this year, but it also was unable to add thereto. Inflation with rising costs are hard to overcome despite heroic endeavors by our Advertising Director, Mrs. Arthur Willard. If one is to believe the comments of the HDMS membership, then the bulletin is serving and filling the needs of the Society. The Board of Editors abhors even the thought of subsidy from membership dues, but leads and the "selling" of the bulletin by the membership to potential advertisers would be most gratefully received.

The most significant event of the year was the designation of Dr. Walton E. Stevens as the new Editor-in-Chief, replacing Dr. John C. Ayres who resigned because of personal reasons.

This being the last Annual Report of the retiring Editor-in-Chief, he would take this opportunity to express his deepest gratitude to all who have made his seven years tenure a most pleasant and rewarding experience.

The Board as usual finds itself greatly indebted to many people for the splendid assistance and cooperation it has received. High praise and gratitude are certainly in order for the HDMS officers, committee chairmen and their respective committee

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members, specially invited contributors, and our printer – the Springfield Offset and Printing Company. Despite the risk of slight in singling out specific individuals for thanks, special kudos for assistance above and beyond the call of duty must be extended to Mrs. Vivian M. Purdy, the Society's Executive Director, and Mrs. Arthur Willard, our Advertising Director.

John C. Ayres, M.D.
Editor-in-Chief

DISASTER MEDICAL CARE COMMITTEE

Communication is being maintained between the agencies involved in Disaster Care. The plan is for further efforts to be made so that the Springfield metropolitan area will be well prepared in the event of disaster.

Frederick Schwendenmann, M.D.
Chairman

INSURANCE, LABOR RELATIONS, AND INDUSTRIAL ACCIDENTS COMMITTEE

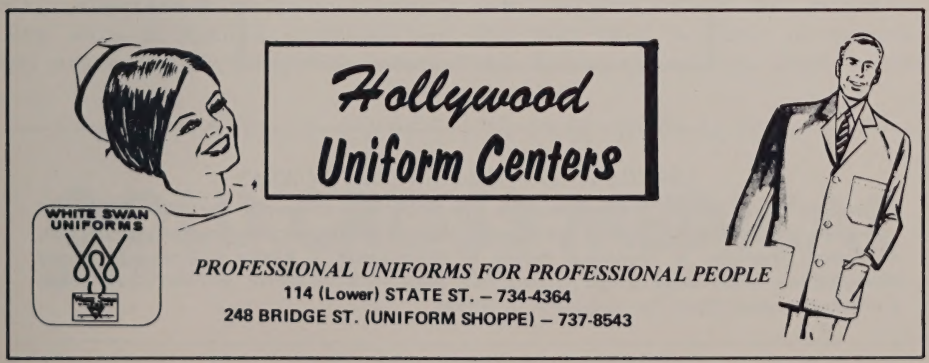
The Insurance, Labor Relations and Industrial Accidents Committee has been inactive this year, the main reason being a desire on the part of the Committee not to duplicate efforts made along these same lines of interest by the Medical Foundation. The problem of the Aetna Life Insurance and its various communications to patients who have grievances about possible overcharges by physicians is being partially solved at a higher level in the medical heirarchy. No problems in labor relations have been brought to the attention of this Committee during the current year. Minor changes in the industrial accidents laws have been made and the membership of the Society is asked to refresh itself on these revisions.

Robert D. O'Malley, M.D.
Chairman

LEGISLATIVE COMMITTEE

Legislation affecting medical practice continues to increase with each session of the Mass. General Court. Of the approximately 8,000 bills filed, the MMS Committee on Legislation had screened out roughly 250 bills for study and evaluation. Some of these bills were refiles from previous years or are new versions of previously considered matters. Nonetheless, a tremendous amount of work was involved at our meetings of November 10, 1972, January 17, February 7, and February 14, 1973. At the January 17 meeting Dr. Boivin, the Alternate Legislative Councilor, also attended. The Hampden District Committee met on February 20, 1973, at which time we sent out individually-typed letters to every member of the General Court in our district stating our position on over 70 bills . Since then we have sent a series of white papers on specific bills to explain our position. The response from the legislators has been most favorable to this approach.

In all, the State Legislative Committee has voted to support 42 pieces of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legislation and oppose 25. Many other bills are under study and negotiation with the General Court. Two examples of this are: (1) legislation to reorganize the Rate-Setting Commission, which we referred to the Tax-Supported Medical Care Committee for study and comment; and (2) proposed legislation regarding Physicians' Assistants is being discussed with Speaker Bartley, although we support a study bill, House 4413, submitted by Rep. Howe.

In addition to the above work, several of the members of the District met with Senator Kennedy in Holyoke for an hour-long meeting on health issues and we will also attend a Special Joint Committee Hearing of the General Court on health benefits and services March 30 to present our views.

We feel that physicians too long have neglected their proper role in the legislative field. However, it should be obvious to all members that such apathy will result in unworkable bureaucratic control through legislation or commission guidelines. Therefore, it is imperative that the members of this district and every district read the MMS and HDMS Newsletter (if not the proceedings of the Council) and maintain their membership in the AMA in order to keep abreast of the national issues on health. No one can logically use the argument that organized medicine does not represent their views *unless* they make their views known and actively participate in their respective medical societies. We also feel that support of BAYPAC is a vital part of the individual physician's interests.

Debates on health programs will continue to occur at both state and federal levels and the people of this country are best served if the physicians contribute their opinions.

James D. Allan, M.D.
Chairman

MALPRACTICE AND MEDICO-LEGAL COMMITTEE

The Committee per se, had no formal meetings – no questions brought before it. The Medico-Legal code has been accepted by the Legal Profession and is now in order. I do not know if the attorneys have been so notified or if they have gotten from us a copy of the new Medico-legal code.

E. W. Beauchamp, Jr., M.D.
Chairman

MEDICAL RELIGIOUS COMMITTEE

Medical Religious Committee have been meeting for thousands of years since, indeed, physicians and priests are often one in the same. Thus, many matters have been mutually satisfied. The situation now is one of relative quiescense and no problems of significant note need to be debated.

The major topic for the coming year will be the question of death in one of its manifestations and will likely range from abortion to euthanasia. A discussion on the subject of abortion has been conducted with no clear cut resolution of the problem reached.

Theodore Hoffman, M.D.
Chairman

MEMBERS' INSURANCE COMMITTEE

In contrast to previous years, the Committee has had a relatively quiet year. The new group business overhead insurance policy which was begun a year ago has been functioning quite well. Another new policy which begun last

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year and which provided disability income coverage to age 65 years, should be of special interest to the younger members. The older disability income insurance program which we have had for some years now providing coverage for a period of ten years of which the first six years it need not be house confined disability, continues in effect. Unfortunately, the personal catastrophe policy, often referred to as "the Umbrella Policy" and administered by Field, Eddy and Buckley Company, was cancelled a year ago and we have been unable to find a replacement on a group basis which would be in any way superior to that which would be available to members on an individual basis. We take pride in being one of the few district societies in the State which has a major medical expense insurance program, and this continues to function well. Such major medical expense is not available under the plan of the Massachusetts Medical Society, and we are fortunate in having such a plan for our District.

There are now 463 policies in force on our accident and health insurance programs. Twenty-three claims were received during the past year, and payments were made in the amount of $36,761.71. Five of these claims were either insures or dependents under the major medical expense policies. Of these claims that were paid during 1972, five are still open and receiving benefits. All five of these claims are serious loss situations so that payments may be necessary for some time.

H. Bernard Tillman, M.D.
Chairman

PEER REVIEW COMMITTEE

The Peer Review – Regular and Reserve – Committees were organized and became operational during 1972.

The Committees derived and adopted conversion factors for use in judging reasonableness of fees in Hampden District, met and coordinated activities with the Medical Charges Review Committee of the MMS, judged 9 cases of fee dispute including one appealed case and furnished one letter of opinion on a reasonable fee for reimbursement under Medicare. In three cases the Committees found in favor of the physician, in three cases the Committees suggested a compromise fee settlement which was accepted by the parties and in two cases the Committees found in favor of the patient or his insurance carrier.

At the beginning of 1973, the Committees had developed a working agreement with the Massachusetts Health Insurance Council under which the Council agreed on behalf of all commercial health insurance carriers writing coverage in Hampden District to pay in full (or up to contract allowance) each fee declared to be reasonable and customary by our Committees and to cease and desist from using their own data to determine "reasonable and customary". Forms for submission of cases for review by the Committees have been developed and the commercial carrier can no longer use the Massachusetts Medical Charges Review Committee in Boston for this purpose except as an appeal from the finding of our local Committees. To date no such appeal has been sought.

Massachusetts Blue Shield remains a

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maverick and to date they continue to use their own data base to determine "reasonable and customary" on the basis of their contracts with participating physicians.

Sincere thanks are hereby extended to Dr. Nickerson of Massachusetts Medical Charges Review, to Messrs. Emmanual Tesoro and Robert Kuehnel of Massachusetts Health Insurance Council, to Dr. Janovsky as secretary of the Committee, to Vivian Purdy for her tireless assistance in the office work involved, and to all the members of the Committees for their time, effort and advice in making this pilot project a success.

Bruce B. Stoler, M.D.
Chairman

PUBLIC HEALTH COMMITTEE

The Public Health Committee in 1972 was essentially inactive, basically because it's chairman was inactive.

The Committee did however, begin to assist the Visiting Nurses Association in developing a closer relationship with the area hospitals. It is hoped that this work may continue in 1973.

James G. Fitzpatrick, M.D.
Chairman

SCHOLARSHIP COMMITTEE

The Scholarship Committee was again active in 1972, distributing the funds available to worthy applicants. In all $1,225 was allotted and distributed as follows:

$775 to 4 medical students
$375 to 4 nursing students
$ 75 to 1 pharmacy student

In addition, a $5 contribution per member per year for scholarship funds was voted by the membership. This should help in allotting help to applicants who could not be accommodated in the past.

Bernard Bloom, M.D.
Chairman

WOMAN'S AUXILIARY

The Woman's Auxiliary continues to do outstanding work. I am sure I speak for the whole Society when I say "thank you" ladies for the job you've done and the job you continue to do.

Carlo Q. Montori, M.D.
Chairman

HIGHLIGHTS OF THE MARCH EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday, March 20, 1973 in the Conference Room of the HDMS. Present were Drs. LaMarche, Stevens, Zacarian, Burke, Moore, Sheehan, Cummings and Mrs. Purdy.

President LaMarche called the meeting to order at 7:05 P.M. Captain Rajowski of the Chicopee Police Department was present as a guest to discuss with the Committee some of the problems that he has with physicians dispending drugs. The Executive Committee assured Captain Rajowski that they would do what they can to cooperate with the police departments.

Dr. Stevens read the minutes of the February meeting which were approved as read by the Committee.

CORRESPONDENCE

A letter of praise for a physician was read to the Committee. The Committee appreciated this letter of praise and a letter of thanks will be sent the patient.

Dr. Traina, President of the Middlesex South District Medical Society, wrote protesting the appointment of two individuals by Commissioner Bicknell to the Department of Public Health Policy Development Group. Dr. Traina asks for cooperation from other medical societies. HDMS will write a letter to Governor Sargent suggesting that more physician representatives should be appointed using doctors in private practice.

An invitation to a farewell party at Westover AFB for Colonel Stuart on April 21, 1973 was read. Most of the physicians had received similar invitations. This was informational.

OLD BUSINESS

A new letter which is to be mailed to non members of the AMA, was presented by Dr. Keroack and approved by the Committee. These will be mailed this month with literature from the AMA.

Dr. Ryan answered the letter questioning him about the final feeling of the MMS Council on abortion. The Council referred the recommendation back to the Interspecialty Committee.

Dr. Gephart wrote that the request of Dr. Foster to become an Associate Member will be referred to the Membership Committee when they meet on April 4th.

A letter from Mr. Holman of the AMA referring to the safety match cover design was read. This will be referred to Mr. Averill.

Dr. Rodkey, Chairman of the Board of Directors of Blue Shield, wrote suggesting

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Theme: DRUG THERAPY

TUESDAY, MAY 29

8:30 Panel. *Drug Interactions, Adverse Reactions, and Side Effects.* Drs. Hershel Jick, Peter Goldman, William T. Branch, Jr., John A. Parrish.
10:45 Panel. *Evaluation of New Drugs – Some Practical Aspects of Drug Therapy.* Drs. Dale G. Friend, Stephen L. DeFelice.
12:15 Section Luncheons: Physical Medicine, Anesthesiology, Radiology, Internal Medicine, Urology, Allergy.
2:15 Panel. *Legal Aspects of Drug Therapy.* Michael R. Sonnenreich, LLB, William E. Hassan, Jr., Ph.D.
4:00 Lecture. *Psychotherapeutic Drugs – An Evaluation.* Gerald Klerman, M.D.
4:40 Lecture. *Updating Antibiotic Therapy.* Louis Weinstein, M.D.

WEDNESDAY, MAY 30

8:30 Panel. *Drug Induced Diseases, Alcohol, Addiction.* Drs. Dana L. Farnsworth, Henry Brill, Vernon D. Patch, Jack H. Mendelson.
11:00 Shattuck Lecture. *A Foundation's View on Health in America.* Daniel E. Rogers, M.D., President, Robert Wood Johnson Foundation.
12:15 Section Luncheons: Occupational Health, Pathology, Dermatology, Obstetrics and Gynecology, Pediatrics, Family Practice, Ophthammology.
2:00 ANNUAL MEETING OF THE SOCIETY
3:30 Annual Discourse. *Quality Versus Quantity in the Training of Medical Students.* Ephraim Friedman, M.D., Dean, Boston University School of Medicine.
7:00 ANNUAL DINNER

THURSDAY, MAY 31

8:30 Panel. *Drug Therapy in Cardiovascular Disease.* Drs. Eugene Braunwald, Arthur A. Sasahara, Jay M. Sullivan, Roman W. DeSanctis, Robert S. Lees.
10:45 Panel. *Hormone Therapy.* Drs. George W. Thorn, Kenneth J. Ryan, J. Stuart Soeldner.
12:15 Section Luncheons: Psychiatry and Neurology, Surgery, Neurological Surgery, Orthopedic Surgery.

a merger of the Peer Review Committee and the Blue Shield cases. This Professional Service Committee to do peer review on Blue Shield cases. This will involve a by-law change and will be referred to Dr. Memery, Chairman, for study and implementation.

NEW BUSINESS

Dr. Peck wrote protesting printing on the back of the Medicare check. The Committee voted to send this to MMS for clarification.

Dr. Zacarian had contacted the Springfield schools through Mr. Monte Flagg and the Longmeadow schools through Mr. Texeira expressing concern about VD. Both men have written indicating their willingness to cooperate with the HDMS in any way decided to continue to combat VD in the schools. Dr. Zacarian will report further after meeting with Mr. Flagg.

Dr. Schwendenmann sent in a copy of a letter that went out to the staff of Wesson Hospital. It stated "According to the legislation, hospitals that can demonstrate effective operating mechanisms of their own will be exempted from the monitoring of the external regional PSRO. The goal of the Joint Commission should be to help all accredited hospitals to achieve exemption status by January, 1976. That, in fact, is not much of lead time, but it is a lead." Dr. LaMarche suggested that a quote from the *MATS Newsletter* be sent to Dr. Kruger.

A brief explanation of the Consumer Credit Counseling Service was given by Mrs. Purdy. She had consulted with Mr. Chaisson, the Executive. This service aids people to be able to pay their bills. The consultation service is free to these people.

Dr. Ayres sent his resignation as Editor-in-Chief of *The Hampden Hippocrat* and was recommended for Editor Emeritus. The Executive Committee approved this resignation with regrets. Dr. Walton Stevens was appointed as Editor-in-Chief. This was approved by the Committee with congratulations to Dr. Stevens.

Dr. Zacarian discussed the Intern and Resident Program and suggested that they be invited as members of the district medical society at a reduced dues fee. Dr. Gephart will be contacted or the MMS Membership Committee, and asked for their opinion on this.

A letter of information about the WMHPC, Inc. from Dr. Monroe was read. Some of the ideas generating from a meeting were excellent and would be points well taken. Copies of this report will be sent to the entire Executive Committee.

A letter from the Springfield Welfare Department was read. They are looking for physicians to do disability examinations. It was voted to write Mr. Rowens and ask for specific examples.

Mr. George Bullen sent a draft of a document covering Long Term Care Facilities and Projective Bed Needs to 1979 for Region I. Dr. LaMarche approved this personally, but copies will be sent to all members of the Committee for comment.

Discussion was held concerning the news article about "Medical Care and Legislators to Probe Costs" and the meeting that will take place on March 30 with Senator Sisitsky. Dr. LaMarche will attend this meeting.

The meeting was adjourned at 9:15 P.M.

The Grievance Committee met and heard four cases.

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FOR BETTER CARE — PHYSICIANS' ASSISTANTS

by
GARDNER COX, II, M.D. and JAMES D. ALLAN, M.D.

Perhaps this article could be entitled "Health Manpower – One Small Aspect", since only the surface of a rather large subject will be scratched.

For some unknown reason, the term "Physicians' Assistants" creates in some the concept that a multitude of semi-trained physicians will be turned out to replace the well-trained physician in the health care field. However, given proper controls, these individuals have proven that they have a place in the delivery of health care to segments of our diverse population. Before all of us looms the following question: Is this an adequate "route to go?" All over the country this approach is being considered and varying degrees of training with specialization of such personnel are being carried out. Legalized accreditation or various study commissions are being enacted state by state. This article is written to examine the potentials involved.

The P.A. is trained for the following basic functions:

History taking – both verbally and using prepared forms.

Physical examination – according to the physicians' requirements and instructions.

Procedure training – drawing blood samples, minor lab testing, cast changes, catheter care, suture removal, dressing changes, and so forth.

Systems approach – to the correlation of data directed toward a more definitive diagnosis by the physician. For example, in symptoms of U.R.I., a step by step examination with the concept of obtaining the necessary history, followed by nose and throat cultures, chest X-rays, sinus X-rays (should they appear indicated), etc.

Records – instruction in the keeping of standard and POMR records.

Public relations – training in basic psychology to help the P.A. adjust to and understand the sick, the elderly, the young, the poor, the disabled, the retarded, and so on.

Confidentiality – discretion is taught in handling information.

Status – trained to be an aide to the physician, no more, no less.

A.P.A. can be a help in the maze of today's practice and it is suggested we consider the following points about P.A.'s:

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– another pair of hands that are constantly in need of "judgment" direction, yet limited to assigned duties;

– ability to do very adequate histories and physicals, which are often better and more thorough than those of the usual, harried physician;

– answering the phone and acting as a one man triage center while scheduling your work load. (However, the P.A. is subject to human error and is only as useful as the quality of training. For the sole practitioner he can be an interested and trained professional with whom cases may be discussed.)

– explaining treatment to patients and emphasizing your instructions, but not making the medical judgments which are constantly yours or being a substitute for the art of medicine;

– examining follow up cases, seeing the old and infirm at home or in nursing homes, and keeping you posted on their medical progress and special problems. (This is particularly effective of the P.A. has seen them with you through a period of hospitalization and understands your outline of treatment.)

– doing the myriad of screening physicals for schools, camps, employers, athletic teams, Boy Scouts, and whatever;

– adapting to your methods of handling cases and become increasingly more valuable with your additional training;

– acceptance of P.A.'s by patients will probably be better than you anticipate.

The answer, obviously, to the question "For better care?" is "yes". The P.A. is directly under the physician's supervision at all times whether the latter is present or not. Within the scope of the physician's combined ability and training, the P.A. can improve the quality of the care the physician now gives and increase the latter's case load. In the Greater Springfield area patients are complaining of the 3 to 4 week waiting period to get an appointment at most physicians' offices. Some are flocking to the emergency rooms by the hundreds for non-urgent treatment and others are even turning to quacks as a last resort.

Finally, in this serious game of federal control vs. private medicine, the guantlet has been thrown down by the PSRO legislation of 1972. H.E.W. guidelines are to be prepared this year and a study of health care delivery is to be completed by 1976, which will include: the quality of our care as compared to our peers, the need of physicians' continuing education, the adequacy of utilization review, our ability to provide services to all and a comparative cost review. No matter how you look at it, this is a tall order to fill.

Although Foundations are a proper step in this direction, Physician Assistants, who are properly trained and certified (not licensed), will be another step.

LIABILITY TIPS

Drug Dependent Minors: Consent to Medical Care: Liability for Payment: Records.

A minor 12 years of age or older who is found to be drug dependent by two or more physicians may give his consent to the furnishing of hospital and medical care related to the diagnosis or treatment of such drug dependency. Such consent shall not be subject to disaffirmance because of minority. The Consent of the parent or legal guardian of such minor shall not be necessary to authorize hospital and medical care related to such drug dependency and, not withstanding any provision of section one hundred and forty-one to the contrary, such parent or legal guardian shall not be liable for payment of any care rendered pursuant to this section. Records shall be kept of such care. The provisions of this section shall not apply to methadone maintenance therapy.

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SPRINGFIELD'S MORTALITY STATS

An unofficial analysis of death certificates filed in the City of Springfield for residents thereof in 1972 reveals that a total of 1,571 persons died during the year. This figure does not include those Springfield residents who died outside of the City nor the 940 deaths of non-residents occurring in the City.

TEN LEADING CAUSES OF DEATH

1. Diseases of the heart	592
2. Neoplasms	271
3. Cerebrovascular lesions	215
4. Pneumonia (all types)	95
5. Accidents	77
6. Diseases of the circulatory system	49
7. Bronchitis	46
8. Cirrhosis of liver	41
9. Generalized arteriosclerosis	20
10. Diseases of skin & cellular tissue	17
11. Suicide	17
12. All other causes	131
Total	1,571

Deaths from heart disease lead the list with 37.7% of all deaths; next, neoplasms with 17.9%; third, cerebrovascular lesions with 13.7%; fourth, pneumonia with 6.5%; and fifth, accidents with 4.8%. Approximately ¾ of the deaths occurred in those 60 years of age and above. Males predominated over females in the ratio of 1.07 to 1. The trend, as in the recent past, continues to point up that chronic diseases, particularly those of the cardiovascular system in the older age groups, are the major killers of Springfield residents.

DEATHS FROM INFECTIOUS DISEASES

Pneumonia	95
Bronchitis	46
Meningococcal Infections	3
Meningitis	2
Total	146

Only 5 deaths were due to infectious diseases considered officially dangerous to the public health. Most of the pneumonia and bronchitis were undoubtedly fatal precipitations superimposed on some other debilitating disease process.

Although infectious diseases are no longer the major death scourges, they are still a major cause of disability. Realizing that there is a tremendous number of cases not officially reported, the following are the leaders:

Gonorrhea	372
Streptococcal Infection	336
Syphilis	131
Hepatitis	89
Tuberculosis	35

Analyzing the 77 deaths occurring to 43 women and 34 men as the results of accidents, the following interesting facts present themselves. First 46 or more than ½ occurred in or about the home as the result of falls primarily in the older age groups. Secondly, 25 persons were killed as the result of traffic accidents – 12 drivers, 5 passengers, and 8 pedestrians. Three died as a result of drowning and 1 from burns. The remaining three died respectively of narcotic drug overdosage, inhalation of poisonous fumes, and chickenbone ingestion and strangulation.

From a mental health point of view, it might be pointed out that there were 17 suicides (13 male and 4 female) with deaths beginning in the early twenties and peaking in the middle age groups. Moreover, there were 11 homicidal deaths (9 male and 2 female).

From a maternal and child welfare point of view, there were no maternal deaths resulting from complications of pregnancy; 2,333 resident live births; and 26 resident stillbirths. Thirty-one infants (under 1 year of age) died for an infant mortality rate of 12.2, which is the lowest rate for some time in the City. Prematurity and congenital malformations contributed to most of these deaths.

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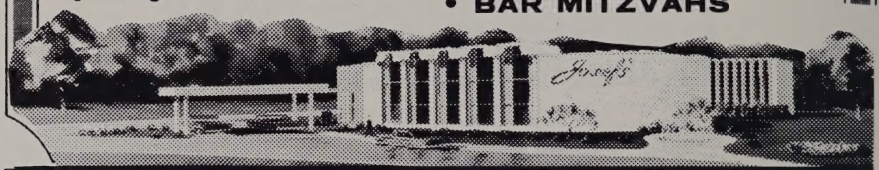

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